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PROBLEMS OF OLDER PEOPLE: FORCED IDLENESS, IMPOVERISHMENT, ILL HEALTH, ISOLATION*

Opening Statement

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THE 1973 Annual Health Conference of the New York Academy of Medicine, *Problems of Older People: Forced Idleness, Impoverishment, Ill Health, Isolation*, seeks to examine critically those policies and programs whose adoption or continuation may enhance the quality of life for older people. The planners of the conference acknowledge the validity of several assumptions or facts:

1) That a decline in organic function accompanies aging and occurs as a normal and inherent but variable feature, increasing in extent and severity in all persons;

2) That despite this inevitable process a highly productive and active life for many older people can be fully attained although, unfortunately, such full attainment is found in too few instances;

3) That the individual and society can do much to assure better health and additional years of productive life for older people through

*The 1973 Health Conference of the New York Academy of Medicine, held at the Academy April 30 and May 1, 1973.

changes in social policy, changes in attitudes, and continued research.

All of us have heard of individuals who continue to remain active in their advanced years. Persons who come to mind include the late great Pablo Picasso, the conductor Arturo Toscanini, and the photographer Edward Steichen. In the medical profession here in New York, for example, colleagues and friends marvel at the continued vitality of Doctors George Baehr and David Barr. Through the writings of Alexander Leaf of Massachusetts General Hospital, Boston, we have become familiar with communities in Ecuador, Soviet Georgia, and Kashmir, where a relatively high percentage of persons live into their 90s and 100s. It must be recognized that increased longevity and continued activity in the older years may be influenced significantly by heredity, but social factors, health habits, and attitudes also play a part. As Dr. Leaf has described it, in those areas of the world which he has visited where communities are characterized by great longevity much attention is paid to diet, and often there is no such thing as retirement. Old people continue to carry out essential tasks in the household and community and to maintain the respect of their neighbors and relatives.

Our experience at St. Luke's Hospital in New York City reinforces what Dr. Leaf has found in remote places. We are convinced that emotional isolation is a social factor which actively promotes deterioration of physical and mental abilities. Such isolation can occur not only when the aged person lives alone, but even when he lives with his family and is not included in the family group. Near our hospital on Morningside Heights in Manhattan there are dwellings with single-room occupancies (SRO). In these depressing places, people, though crowded together, are living in miserable isolation from one another, with much physical and emotional sickness. We sought to induce these people to know one another, to collaborate in order to help themselves, and to develop a sense of community and thus to improve their physical and psychological well-being. Since almost all the residents were on welfare, we found that during the last days before their check arrived many went hungry. We tried a simple and perhaps obvious measure. We supplied a small amount of money to the residents just before the public-assistance checks arrived in the mail so that they could plan a menu, purchase food, and prepare and serve a fortnightly group dinner. Within a short period a sense of personal identity and community was emerging, the SRO residents were undertaking other tasks together, such

as electing representatives for activities, and there was improvement in their health and in their use of health facilities. When one SRO building was torn down later, most of the people decided to move together in groups to new quarters.

Scientists may find ways of interfering with the process of aging, as Dr. Alex Comfort suggests: if not by stopping it, at least by slowing it down. But, perhaps more fundamentally, we need to emphasize in our reaction to older people what one of our speakers, Sharon Curtin, stressed in her book *Nobody Ever Died of Old Age:* a respect for the human condition. "I sometimes have a dreadful fear," she writes, "that mine will be the last generation to know old people as friends, to have a sense of what growing old means, to respect and understand man's mortality and his courage in the face of death."

Our meeting this year focuses on several major problems of older people. The discussion will range from a review of trends in legislation and in public programs dealing with older people to an analysis of the problems of delivering health and social services. Changing patterns of illness and potentials for successful intervention to deal with health problems will be discussed in a context which is sensitive to the fact that the well-being of the aged is not only influenced by medical care but also by the quality of housing, social services, recreation, and work experiences. Speaking of work experiences, one cannot underestimate the significance of attitudes toward work, job satisfaction, a possibility of new careers in midlife, or service in creative leisure activities for personal contentment and health.

In our first panel, National Policy: The Background of Current Issues, we shall provide an opportunity for the national administration to discuss its program for the aged and for representatives of Congress and of organizations of the aged to respond. It is interesting to note that only recently the White House and Congress seem to have reconciled their differences which they have had on the Older Americans Act. Yet the conflicts between Congress and the president on policies for the aged remain. The Nixon administration has proposed changes in the Medicare program, including an increase in Medicare deductibles and coinsurance features which many Congressmen oppose.

Assuming that this controversy over Medicare deductibles is resolved, where do we go from here in our present Social Security and welfare programs? There is a widely recognized problem in integrating

health and social service programs provided by various levels of government—federal, state, and local—so that they do not distort medical patterns of service. There is increasing concern that many of our social programs may not be working and that the twin goals of equity to the recipients and efficiency in the delivery of services are being violated.

In our attempts to restructure health services for equity and effectiveness we are particularly fortunate to have visitors from Scandinavia and Britain who have pioneered in services to older people. While patterns of services in foreign countries may serve as precedents for programs here, our major interest in our second panel is to have a broader perspective from which we can examine possibilities for improvements in programs in the United States.

A particular matter of concern in the pattern of services for the aged is the nursing home. Vigorous remedial action is necessary to upgrade the quality of care that people receive in these institutions. Among the aged we find a combination of physical and mental problems which calls for the careful cooperation of psychiatists and the medical profession in general. Finally, the search for alternatives to hospitalization is aimed not only at savings in costs but for better care and a more productive life for older people.

The third panel, Health-Illness Spectrum in the Aged, is concerned with the impact of changing patterns of illness on medical care and social arrangements for older people. What do we know in clinical medicine and what are the potentials for effective intervention? How do we treat the problems of death and dying? This is an issue which is not only of increasing concern to the medical profession and the public, particularly families of older people, but also an area in which the Committee on Medicine in Society has recently formulated a statement which has been approved by the Council of the Academy. The statement appeared in the April *Bulletin of the New York Academy of Medicine.** Our committee has expressed concern with the hardships caused by heroic measures employed to prolong life in terminal illness and the need to limit the pain and suffering of the patient and his family. We urge "the employment of conservative, passive medical care in place of heroic measures in the management of a patient afflicted with a terminal illness."

The social factors of forced idleness, impoverishment, and isolation

*Statement on measures to prolong life. *Bull. N. Y. Acad. Med.* *49*:349-51, 1973.

will be treated in our final panel. These issues are not only of intrinsic importance, but affect the health and well-being of all people. There may be some confusion about the role of the physician in dealing with social problems. As a citizen his concern with what is happening in society is no different from that of any other citizen. As a physician he must inevitably focus on specifics rather than vague relations between social factors and health. Because the physician has a responsibility for careful analysis of causation and effectiveness of programs, his interest in social problems must be both broad and deep. He must be cautious in the analysis of cause and effect, but decisive in suggesting a remedy where evidence indicates that such a remedy will work.

This is the spirit in which we open the 1973 Annual Health Conference of the New York Academy of Medicine. Through a frank exchange of views, issues may be clarified, unwise suggestions may be exposed, and fruitful proposals may be advanced. Conference participants, having retreated for these two days from their usual activities, may then return to their home bases refreshed, enlightened, and highly motivated to work to improve the human condition.